Key Points

DDS Provision of Selected Services for Clients with Intellectual Disabilities

Section I: Residential Care and Costs

- The Department of Developmental Services (DDS) receives about half the total funding for providing publicly staffed 24-hour residential care, yet it serves only about 25 percent of the clients in 24-hour care.

- Private providers have received slightly more in overall funding since 2007 (8.5 percent in three years), but the agencies have been serving more clients, so their funding per client has remained flat.

- Despite the higher FTE count in DDS public residential settings, there is significant use of overtime. In FY 10, DDS overtime costs were $45.3 million, including $15 million at Southbury.

- Most of the costs of residential care are for program services, including staffing.

- Room and board costs are a much smaller portion of total costs. Some of the room and board costs may be higher in the private sector (e.g., property costs, taxes and other room and board expenses), while some costs in DDS may be absorbed in the larger state budget.

- DDS is already moving toward a largely private-driven residential system:
  - in FY 10 there were 223 fewer clients in DDS public residential care than in FY 07, a decrease of 16 percent in three years;
  - DDS has had a policy of no new placements to its public residential settings for a number of years;
  - the department is vigorously implementing provisions of the Southbury settlement agreement;
  - DDS converted 17 homes from public to private in FY 10; and
  - the department is currently eliminating another 5 programs in the current budget cycle.

- DDS staff numbers are decreasing through normal attrition. Since July 2011, 37 permanent developmental service worker positions and six supervisor positions at DDS residential care locations were vacated through retirements and resignations. Another seven instructors and three school teachers at public day programs terminated from state service. Those positions have not been refilled.

Key Points

- During this period of downsizing the public sector delivery of services to a private one, the per diem costs of serving the clients who remain in the public settings is likely to remain high. This is because DDS cannot lay off staff due to both the 2011 SEBAC agreement and restrictions on layoffs and transfers in labor agreements the State has with its collective bargaining units.

- The number of persons on the DDS waitlist for residential services has increased to almost 550 people, an increase of 13 percent in the last two years alone.

- Individual client costs in the public sector are not calculated because there is no rate-setting for services in DDS facilities or homes.

- Even under the new rate-setting system, which bases funding on a client's level of need, rates will apply only to private providers and not to the DDS settings.

Section II: Day/Work Programs and Costs

- Overall, more than 90 percent of all DDS clients participate in day or work programs that are operated by private providers, and the trend is increasing. Fewer than 5 percent attend public programs operated by DDS.

- A trend that is of concern is the percentage of clients who are competitively employed, which declined from 5.1 percent in 2007 to only 3.7 percent in 2011.

- Of the 4,119 clients in 24-hour residential care and the subject of the study, there were four common day/work programs in which clients participated:
  - 2,603 (63 percent) were in day support options;
  - 1,185 were in group supported employment;
  - 178 were in a sheltered workshop program (many with low level of need scores); and
  - 153 clients under aged 21 were in programs supported by their local school district (LEA).

- The average cost per person of private day/work programs for clients in 24-hour residential care in FY 10 was $23,938. For those clients with the highest level of need score "8", the costs were significantly higher -- an average of $44,329.

- The average cost of the day/work program at Southbury Training School is $37,202 compared to $22,554 for STS residents attending privately staffed programs off campus.

- The average LON score for the Southbury clients who stayed on campus for their day/work programs was 5.23, not much higher than the average LON of 5.05 for STS residents who went off-campus for their programs, but their programs were considerably less expensive.

Section III: Costs of Care and New Rate Structure

- DDS has had rate guidelines in place since 2006 that link funding with a client's need and supports, but the guidelines only applied to new clients or those moving to a new placement.

- DDS will have to comprehensively revamp its rate structure in order to comply with CMS provisions requiring a rate methodology based on utilization and level of need.

- DDS has begun implementing an attendance-based requirement of 90 percent for providers involved in the day/work programs.

- Other aspects of the new rate structure will take much longer -- DDS has established a transition process of 7.5 years for fully implementing a new rate structure to meet the CMS requirements.

- The department will first phase in those providers whose current rates are furthest from the funding guidelines so that they will have time to adjust.

- The department has also established two subcommittees to help with the transition – one to help develop policies and procedures during the phase-in period and the other to determine a sustainable wage and benefit package for provider employees under the new system.

- Almost half of all clients in 24-hour private CLAs exceed the residential funding thresholds; almost all clients with a LON score of 1 or 2 are over the funding threshold.

- Forty-eight percent of clients who receive 24-hour residential care and receive private day/work program supports exceed the funding guidelines. A higher percentage of clients at either extreme of the LON scores exceeded the thresholds -70 percent of clients with a LON of 1, and 81 percent of clients with a LON of 8.

- The percentages of clients that exceed the guidelines indicate that the new rate system when applied will have significant consequences for some private providers of both residential and day/work programs.

- DDS will need to implement its phase-in schedule for residential and day/work

programs as this gradual transition to the new rates will help absorb any funding shocks to individual providers.

- DDS' utilization review process is implemented in the regions with little central office oversight.

- DDS information technology systems are inadequate and in need of upgrades, and there needs to be more emphasis on accuracy of client data entered in the system and in keeping it current.

Section IV: Quality Assurance

- There were 10 deficiencies per public group home for the 42 inspections conducted in FY 10, while there was an average of 6.4 deficiencies cited in the private CLAs based on 401 inspections in FY 10.

- As an indication of continued noncompliance, only 13 percent of the private homes were cited for the problem of complying with "plans of correction," while 38 percent of the DDS-operated homes were cited, almost three times the rate.

- Quality improved in the 17 homes that were converted from public to private:

    - there were fewer deficiencies in all categories after the conversion to private homes; and
    - the average percentage drop in the total number of deficiencies was 44 percent.

- Quality was also better in the private ICFs/MR – the facilities inspected and certified by the Department of Public Health.

- On average there were 1.2 fewer deficiencies found in the private ICFs/MR than in the public facilities. Three deficiencies were found for each private facility inspected with deficiencies, and 14 of the 65 homes had no deficiencies. The 30 public facilities had an average of 4.2 citations and no public facility had a deficiency-free inspection.

- Six of the 30 public ICFs/MR (20 percent) were cited as having serious deficiencies, while only four of the 69 private ICFs/MR (6 percent) were cited.

- Connecticut is one of 11 states that covers comprehensive dental services to adult Medicaid clients, but provision of dental services is a concern among clients with intellectual disabilities.

- Only 2,800 of the 4,387 clients in 24-hour care had a Medicaid dental claim or

payment according to Medicaid data examined Thus, the average Medicaid dental costs for those clients with dental claims were about $185. The most plausible explanation for the apparent underutilization is the lack of access to dental providers accepting Medicaid clients.

- Typical Medicaid reimbursement rates are about half what commercial insurers pay for services.

- DDS has established a number of dental clinics and a dental coordinator position to help ensure their clients' dental needs are met.

- DDS has developed a comprehensive set of guidelines for minimum preventive care including regular physicals, routine lab work, cancer screenings and the like.

- DDS has no systematic tracking to ensure these guidelines are followed.

- Medicare and not Medicaid is the primary payer for most outpatient services so Medicaid data would be of limited use in assessing what services the dually eligible clients have received.

- The Department of Social Services, as the state's Medicaid agency, is aware of the unique challenges to delivering health care services to dually eligible clients and is currently developing a better system to link health records for the two programs.

- The DSS plan for an Integrated Care Organization (ICO) model will first focus on elderly clients eligible under both Medicare and Medicaid programs. The planning groups appear weighted to elderly clients.

RECOMMENDATIONS

1. **The Department of Developmental Services should evaluate all residents receiving 24-hour care at the five regional centers for possible placement in the community. Using the interdisciplinary team concept established by the Southbury Training School Consent Agreement, each team would exercise its professional judgment in recommending the "most integrated setting" appropriate to the needs of each regional center resident. For purposes of the agreement, the "most integrated setting" is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."**

   For residents of Southbury and the regional centers, a rejection of a community placement should be revisited periodically. If the interdisciplinary team makes a recommendation for a community placement, which is rejected by the guardian, or family member, or client, the team should evaluate the resident's situation each year and present its recommendation for a family, guardian, or client decision.

2. **The Department of Developmental Services should continue its phasing out of providing 24-hour residential care in any of its DDS settings, but that it accelerate its efforts through:**

   - **Using DDS CLAs only for residential placements for clients from more restrictive public settings like Southbury or the regional centers, and as a transition phase only;**

   - **DDS should not refill any direct care or direct service positions vacated through attrition in any of its residential or day program; and**

   - **DDS should conduct a staffing assessment at its residential locations in light of the 16 percent reduction in clients. For the clients still residing at DDS homes and facilities, DDS should use the LON assessment tool to determine the level of staffing needed (as it would in contracting for private placements.) Where staffing levels are higher than comparable in the private sector, DDS should redeploy staff to serve clients on the residential care waiting list in their homes or to provide respite care, within labor contract provisions.**

   - **Ultimately, the only residential care that should be operated by DDS is to provide care for extremely hard-to-place clients and for those clients that the superior or federal (not probate) court directs into DDS care. This should involve about .5 percent of the 24-hour residential care population or 25 people.**

3. **DDS should reduce its overtime by at least 10 percent as recently required by the Office of Policy and Management, including through implementing those measures similar to those recommended by the Department of Children and Families in its overtime reduction report to OPM.**

4. **In future contracts DDS has with private providers, the department should examine the salaries paid to direct care workers considering:**

   - **what they are paid relative to the agency's executive director's salary;**
   - **relative to wages needed for self sufficiency standards as calculated periodically by the Office of Workforce Competitiveness and the Office of Policy and Management and those that may be developed by the DDS Sustainability Subcommittee; and**

- **income levels that qualify persons and families for eligibility for state Medicaid and other assistance.**

5. **As a condition of future contracts with a private provider, the Department of Developmental Services should also ensure that the provider has complied with the requirements of cost reporting, including the submission of forms on executive director's salary.**

6. **The Department of Developmental Services should continue to phase out the provision of public day/work programs, with the overall goal to implement a single private delivery system for day/work services. The department should not refill any positions that are, or become, vacant in public programs, and shall redeploy existing staff to other direct services in the community as opportunities allow.**

7. **Further, the Department of Developmental Services should conduct a staffing assessment of its current staffing levels for its public day programs, using the day/work LON scores in the private programs as a guide for level of resources needed, and redeploy staff resources over those levels to other services.**

8. **As recommended for clients receiving 24-hour staffed residential services, the Department of Developmental Services should adopt a centralized utilization review process for clients exceeding the day/work program funding guidelines. The review process should be conducted by a review panel consisting of regional directors or their designees, the DDS central office director of operations, and the central office budget director or their designees. The results of the utilization review process should be electronically tracked so that the department can compare the number of clients exceeding the threshold in each region, the reason, and the total amount exceeded. This information should be reported as a separate section in the Management Information Report at the end of each fiscal year.**

9. **Each client's Planning and Support Teams (PST) should review each client's day program relative to his/her LON. The objective for each client should be that he or she is participating in the most productive, meaningful work or day program in the most inclusive environment as possible. The client's PST should also be examining results of programs, such as day service options, that are geared to building skills to transition a client to a more competitive environment to ensure these outcomes are measured.**

10. **The Department of Developmental Services should adopt a centralized utilization review process for clients exceeding the residential funding guidelines. The review process should be conducted by a review panel consisting of regional directors or their designees, the DDS central office director of operations, and the central office budget director or their designees. The results of the utilization review process should be electronically tracked so that the department can compare the number of clients**

exceeding the threshold in each region, the reason, and the total amount exceeded. This information should be reported as a separate section in the Management Information Report at the end of each fiscal year.

11. **The Department of Developmental Services should remind its case managers of the importance of keeping client automated records up to date.**

12. **The Department of Development Services should randomly audit a sample of cases in its client demographic database to ensure client information is accurate.**

13. **The results of quality inspections should be shared with all clients' Planning and Support Teams, which would include guardians and families. The results can be part of an education process about private community settings, and may help some clients' families reach a positive decision about moving from an institutional facility to the community.**

14. **The Department of Developmental Services and the Office of Protection and Advocacy (OPA) should ensure staff and client participation and involvement in the planning for the Integrated Care Organization model, especially as it pertains to dually eligible clients who are under 65. Both DDS and OPA should ensure that any health care delivery model reduces duplication, prioritizes preventive care, incorporates a data reporting system that easily tracks and reports on preventive care and screening clients have received, and can be used as part of a performance measurement and quality assurance system.**